VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 30, 2015

Ms. Tasha Thomas, Administrator
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Ms. Thomas:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 7, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 04/14/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING _____ B. WING _____	C 04/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT OTTER CREEK	350 LODGE ROAD MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on site investigation of a self-reported incident was conducted by the Division of Licensing and Protection on 4/7/15. There were regulatory findings.	R100	Please see attached plans of correction.	
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that necessary services for nursing and medical needs were met for 1 resident, Resident #1. Findings include: 1. On 4/7/15 at 10:50 AM, during medical record review for Resident #1, a progress notes written by the Licensed Practical Nurse (LPN) on 1/29/15 states that Registered Nurse was notified at approximately 2:00 AM that during transfer Resident #1 exhibited involuntary muscle contractions in all extremities that were seizure-like. Further review of the medical record does not provide evidence that the (RN) had followed up with the resident nor assessed him/her. The RN confirmed at 11:22 AM that the resident was not assessed following the incident. 2. Continued review of the medical record	R126		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Registered Nurse — (X6) DATE: 4/27/15

R126 - A607 POCs accepted 4/28/15 BBartell RN | PMC

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R126	Continued From page 1 identifies that on 9/4/14 that Resident #1 had throat pain by the med. tech and that the resident's "glands felt swollen". The resident presented to the LPN, upon her visit to the resident that s/he was resting comfortably in bed and upon palpation, no swelling was noted in resident's submandibular glands. The RN confirmed at 12:15 PM that the resident was not assessed by the RN regarding the incident. 3. Further review of the medical record presented that the resident had, one one occasion, sustained a fall and on another occasion had bruising of unknown origin. Documentation of the incidents were completed by the LPN and there is no evidence that the resident was assessed by the RN. The RN confirmed at 12:32 PM that there is no evidence that residents who have falls are being assessed by the RN prior to staff assisting them to get up off the floor.	R126		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance	R188		

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R188	Continued From page 2 directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that instructions in case of resident's death was included in the medical record for 1 resident, Resident #1. Findings include: During record review on 4/7/15, there was no evidence of instructions in case of the resident's death listed. Per interview with the Registered Nurse (RN) Manager at 10:50 AM, the resident's nor their families make that determination until death is near. Reviewed with the RN that Resident #1 was an untimely death and asked what the facility would do if they were unable to contact the family or legal guardian. The RN stated that s/he had not thought of it like that before and confirmed that the regulation needs to be followed.	R188		
A 607 SS=D	VI Resident Care and Services 6.7 Care Plans The licensee, the resident and/or the resident's legal representative shall work together to develop and maintain a written resident care plan for those residents who require or receive care. The care plan shall describe the assessed needs and choices of the resident and shall support the resident's dignity, privacy, choice, individuality, and independence. The licensee shall review the plan at least annually, and whenever the resident's condition or circumstances warrant a	A 607		

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A 607	Continued From page 3 review, including whenever a resident's decision, behavior or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to insure to develop and maintain a written resident care plan for 1 of 1 residents reviewed, Resident #1. Findings include: 1. During record review for Resident #1 on 4/7/15 at 10:50 AM, the care plan reflected that the resident was to be on every 2 hour safety checks, but documentation presented that it only occurred on the night shift. Per interview with the Registered Nurse (RN) Manager at this time, s/he stated that the checks were only to be done by the night shift, but did confirm that the care plan stated every 2 hours and that would indicate it was to be done every 2 hours. 2. Resident # 1 had several documented progress notes regarding skin issues and bleeding, in relation to skin tears or scrapes from falls. There is no evidence of a written care plan to address skin integrity specific to monitoring and treating of wounds. The RN confirmed at 10:50 AM that there is no care plan for this problem. Per interview at 10:50 AM, with the RN, there is no evidence of a written care plan to address skin integrity specific to requiring monitoring and treatment.	A 607		

The Residence at Otter Creek Plan of Correction-ALR

R126

Deficiency #1

5.5 General Care: 5.5A Upon admission to a residential care home, necessary services shall be provided or arranged to meet the residents personal, psychosocial, nursing and medical care needs.

Deficiency: Based on staff interview and record review, the facility failed to ensure that necessary services for nursing and medical needs were not met for one resident. Resident #1.

#1: Action to correct deficiency:

Licensed Practical Nurses to report to Registered Nurses any follow up incidents in a timely manner. Reporting to Registered Nurses will be communicated via email when a RN is not present in the building. LPNs were educated on what constitutes an assessment by a RN on 4/27/2015 (see attached) at nurse's meeting, as well as the way to communicate that a follow up is needed.

#2: Measures to assure this does not recur:

Registered Nurses to read 24 or 72 hour communication report which contains all nurse's notes, to monitor for incidents requiring a registered nurse follow up. Registered Nurses will continue to read incident reports and sign off as previously required, however, a follow up note to be completed by Registered Nurse with an assessment.

#3: How corrective action will be monitored:

A 24 or 72 hour communication report from our electronic medical record will be printed by Registered Nurses, with completion of follow up assessment and nurse's note, the registered nurse will be required to initial next to each resident assessed. One week's worth of 24 or 72 hour communication reports will be kept in a binder in Resident Care Director's office.

R 188

Deficiency #2

5 Resident Care and Home services: 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of residents death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advanced directives, if any completed; and a copy of the document giving legal authority to another, if any.

Deficiency: Based on staff interview and record review, the facility failed in insure that instructions in case of resident's death was included in the medical record for one resident, Resident #1.

#1: Action to correct deficiency:

By 6/1/2015, a letter will be composed and distributed to all residents or power of attorney requesting instructions in the event of a resident's death.

#2: Measures to assure this does not recur:

Going forward, any new admissions will be required to have a funeral home listed. This will be placed on the application for residency which is reviewed upon admission. From the application for residency, the information will be placed in the individual resident's electronic medical record.

#3: How corrective action will be monitored:

Upon admission this will be reviewed while creating individual resident's chart. This will be monitored by Reflections Director or Resident Care Director, or designee.

A607

Deficiency #3

6 Resident Care and Services: 6.7 Care Plans The licensee, the resident and/or the resident's legal representative shall work together to develop and maintain a written resident care plan for those resident's who require or receive care. The care plan shall describe the assessed needs and choices of the resident and shall support the resident's dignity, privacy, choice, individuality, and independence. The licensee shall review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident's decision, behavior or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement.

Deficiency: Based on staff interview and record review, the facility failed to insure to develop and maintain a written resident care plan for one of 1 of 1 resident's reviewed, Resident #1.

#1: Action to correct deficiency:

By 6/1/2015, all care plans for current residents will be reviewed and revised by Reflections Director and Resident Care Director to insure all information is correct and current for each individual resident.

#2: Measures to assure this does not recur:

Care plans to be reviewed by floor nurses and registered nurses on a more frequent basis. Care plans to be updated as resident care needs change, at request of family and as required by regulation.

#3: How corrective action will be monitored:

Electronic medical record will quarterly prompt registered nurse to complete review and sign off. With quarterly review, each resident's care plan will have changes made to insure focuses/goals and interventions are added or resolved. With annual assessments for each individual resident, care plan will be reviewed and signed off my Resident Care Director (RN) to insure annual review.

Agenda for Nurse's meeting 4/27/2015

- New resident issues
- Equipment and Environmental concerns
- Staff Concerns
- Incidents that require RN follow up and no assessing by LPNs